

MaineCare Services

An Office of the Department of Health and Human Services

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

Department of Health and Human Services MaineCare Services 442 Civic Center Drive # 11 State House Station Augusta, Maine 04333-0011

> Tel: (207) 287-2674; Fax: (207) 287-2675 TTY: 1-800-423-4331

May 15, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: Final Rule: Ch. 101, MaineCare Benefits Manual, Chapters II & III, Section 5,

Ambulance Services

The adopted rules reflect changes to this section to increase Ambulance Services base rates that will include ancillary services. Ancillary services, which include oxygen, oxygen administration supplies such as disposable oxygen masks, intravenous therapy, EKG, endotracheal intubation, pulse oximetry, telemetry and defibrillation, will no longer be billed separately. Registered Nurse (RN) services will also no longer be billed separately as the base rate for Specialty Care Transport has been increased. A definition of Specialty Care Transport has been added. These changes are being made so only HIPAA compliant codes will be utilized. Other changes to this section were made to update policy language.

A public hearing was held on March 11, 2009. The comment deadline was March 23, 2009.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm or, for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

A copy of the public comments and Department responses can be viewed at and printed from the Office of MaineCare Services website or obtained by calling 207-287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at 624-7539, option 8 or 1-800-321-5557, extension option 8 or TTY: (207)287-1828 or 1-800-423-4331.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: Ch. 101, MaineCare Benefits Manual, Chapter II and III, Section 5, Ambulance Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The adopted rules reflect changes to this section to increase Ambulance Services base rates that will include ancillary services. Ancillary Services, which include oxygen, oxygen administration supplies such as disposable oxygen masks, intravenous therapy, EKG, endotracheal intubation, pulse oximetry, telemetry and defibrillation, will no longer be billed separately. RN services will also no longer be billed separately as the base rate for Specialty Care Transport has been increased. A definition of Specialty Care Transport has been added. These changes are being made so only HIPAA compliant codes will be utilized. Other changes to this section were made to update policy language.

The proposed rule does not impose an economic burden on small business, municipalities or counties.

See http://www.maine.gov/bms/rules/provider_rules_policies.htm for rules and related rulemaking documents.

EFFECTIVE DATE: May 21, 2009

AGENCY CONTACT PERSON: Darrell S. Wood, Health Planner **AGENCY NAME:** Division of Policy and Performance

ADDRESS: 442 Civic Center Drive 11 State House Station

Augusta, Maine 04333-0011

TELEPHONE: (207)-287-6348, FAX: (207) 287-9369

TTY: 1-800-423-4331 or 207-287-1828 (Deaf/Hard of Hearing)

10-144 CH. 101 MAINECARE BENEFITS MANUAL CHAPTER II

SECTION 5 AMBULANCE SERVICES Established 9/1/68
Last Updated: 5/21/09

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5.01 **DEFINITIONS**

- 5.01-1 **Ambulance Services** are those services, which are conditionally, temporarily, or fully licensed, in the state or province where services are provided as documented by written evidence from the appropriate governing board, and that provide emergency care and/or transportation for the ill or injured person, as ordered or approved by a physician, when it is medically necessary.
- 5.01-2 **Basic Life Support (BLS)** ambulance service is one that provides transportation plus the equipment and staff required for basic medical services. These services include, but are not limited to, the following within the scope of the staff's licensure: control of bleeding; splinting fractures; treatment of shock; delivery of babies; cardiopulmonary resuscitation (CPR); and automatic interpretation defibrillation.
- 5.01-3 **Advanced Life Support (ALS)** ambulance service is one that provides complex specialized life-sustaining equipment. Such ambulance vehicles shall be appropriately licensed and equipped, and be staffed by appropriately licensed personnel who are trained and authorized to provide advanced life support. Such training includes administering IVs, establishing and maintaining a member's airway, defibrillation of the heart, and performing other ALS procedures or providing services including, but not limited to, cardiac monitoring.
- 5.01-4 **Air Ambulance Service** provides rapid transportation by air when the member's condition is such that the time needed to transport, or the necessity of transportation by land poses a threat to life or seriously endangers the health of the member. Examples are as follows: (1) hemodynamic, pulmonary, and/or neurological instability with potential for rapid deterioration requiring critical care life support (monitoring, personnel, medications, and/or specific equipment) during transport that is not available from the local ground ambulance service, (2) the member's clinical condition requires that the time spent out of the hospital environment (in transport mode) be as short as possible, and/or (3) the member is located in an area which is inaccessible to regular ground traffic.
- 5.01-5 **Reasonableness** in regard to the use of ambulance service is determined by the treatment of the illness or injury involved. Reimbursement may be denied on the ground that the use of the ambulance service was unreasonable with respect to the treatment of the illness or injury involved.
- 5.01-6 Medical Necessity is established when any other method of transportation is contraindicated for that member's medical condition. Examples of medical necessity include, but are not limited to:

 (1) the necessity to transport the member immediately as a result of an accident, injury, or acute illness;
 (2) the necessity to restrain the member;
 (3) the member being unconscious or in shock;
 (4) the member requiring oxygen or other emergency treatment during transportation;
 (5) the requirement to keep the member immobile due to a fracture or a suspected fracture not yet set;

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5.01 **DEFINITIONS** (cont.)

(6) the member having sustained an acute stroke or myocardial infarction; (7) the member suffering severe hemorrhage; (8) confinement of the member to bed before and after the ambulance trip; (9) the necessity to move the member by stretcher only.

If the condition is one of the last two (8, 9) cited above, the reason why the member was bed confined or could only be moved by stretcher must be documented in the member's record.

Effective 5-21-09

- 5.01-7 **Base Rate for Ambulance Service** is the rate allowable for reimbursement for a one way trip from a place of origin to an authorized destination. The Base Rate excludes mileage charges, but includes designated supplies, equipment, and ancillary services.
- 5.01-8 **Ambulance Service for Emergency Involuntary Admission to a Mental Hospital** is a one way trip from a place of origin to an inpatient psychiatric facility performed under the auspices of an "Application for Emergency Involuntary Admission to a Mental Hospital," sometimes referred to as a "Blue Paper," which is endorsed by a judge of a Maine court of competent jurisdiction.

Effective 5-21-09

5.01-9 **Specialty Care Transport (SCT)** is the interfacility transportation of a critically injured or ill member by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-paramedic.

5.02 **ELIGIBILITY FOR CARE**

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

It is the responsibility of the provider to verify a member's eligibility for Ambulance Services. When a newborn for whom MaineCare eligibility has not yet been determined requires Ambulance Services, the provider shall ascertain whether the mother is currently MaineCare eligible. If the mother is eligible, the provider shall assume that the child is eligible.

5.03 **DURATION OF CARE**

Effective 5-21-09

Each Title XIX and XXI member is eligible for as many covered services as are medically necessary, as long as the member meets the eligibility for care requirements set forth under paragraph 5.02. The Department reserves the right to request additional information to evaluate medical necessity.

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5.04 COVERED SERVICES

A covered service is a service for which payment to a provider is permitted under this Section of the MaineCare Benefits Manual (MBM). The types of ambulance services that are covered for eligible individuals are subject to medical necessity and those which meet the following criteria:

5.04-1 **Transportation to the hospital or medical care facility** which:

- 1. Has an available bed or outpatient service and;
- 2. Has the equipment and personnel to provide the required services.

5.04-2 Transportation from and to the points listed below:

ORIGIN DESTINATION

Member's Residence Nursing Facility (inc. ICF-MR)

Scene of Accident or Illness Hospital

Scene of Accident or Illness Nursing Facility (inc. ICF-MR)

Nursing Facility (inc. ICF-MR) Hospital

Nursing Facility (inc. ICF-MR)

Nursing Facility (inc. ICF-MR)

Nursing Facility (inc. ICF-MR) Member's Residence

Hospital Nursing Facility (inc. ICF-MR)

Hospital Hospital

Hospital Member's Residence

When moving between two facilities having the same level of care, social/familial and medical factors must justify the move, and the move must be in accordance with the relevant provisions of the MaineCare Benefits Manual (MBM).

5.04-3 **Emergency medical services provided at the scene** of illness, injury or accident when transporting the member is not necessary. Examples include, but are not limited to: (1) A member is pronounced dead after the ambulance was called but before the deceased member is picked up: (2) An ambulance that assists at the scene of an accident but does not transport the member. The emergency service may be reimbursed for one Base Rate only.

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5.04 **COVERED SERVICES** (cont.)

5.04-4 "**Down Time**" spent waiting for a member to receive medical care at a medical facility. Reimbursement is made for "Down Time" when the charge is less than the Base Rate for a return trip. Reimbursement for covered "Down Time" is made in 30-minute increments beginning with the second half-hour of waiting time.

5.05 RESTRICTED SERVICES

Effective 5-21-09

5.05-1 Air Ambulance Services

- A. Air ambulance services are covered services when the provider demonstrates each of the following conditions are met:
 - 1. The attending physician certified it is medically inadvisable for the member to travel any other way; and
 - 2. Prior authorization has been obtained from the Office of MaineCare Services, Prior Authorization Unit (see Section 5.08-2). Before requesting prior authorization for air ambulance services, determine which type (i.e.: fixed wing or helicopter) would be the most medically appropriate, quickest and least expensive and provide the amount of time required for both types of transport in order for Prior Authorization Unit staff to determine the most medically appropriate type of service for the MaineCare member; or
 - 3. The member is airlifted from the scene of an injury or emergency illness for which aeromedical transport has been determined to be necessary by EMS personnel at the scene and authorization was granted retroactively. The medical condition must require immediate and rapid ambulance service that could not be provided by ground transportation because: (1) the point of pick up is inaccessible by land, obstacles (i.e.: heavy traffic) or (2) great distances are involved in getting the member to the nearest hospital with appropriate facilities.
- B. The provider shall provide the most medically appropriate and cost efficient aircraft for each case, and the aircraft must comply with all regulations for air ambulance of Maine Emergency Medical Services (MEMS), or comparable other jurisdiction. The air ambulance provider shall arrange for ambulance transfer service between airport and hospital at the end of each trip.
- C. The provider shall utilize air ambulance personnel trained and licensed at the paramedic level, and any additional personnel required by the physician in charge. Air ambulance personnel must meet all requirements of Maine Emergency Medical Services regulations, or those of a comparable other jurisdiction, including having completed a course in altitude physiology and air operation safety. Copies of licensure of employees and air ambulances shall be on file with the air ambulance provider, as well as insurance certificates for each aircraft used.

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5.05 **RESTRICTED SERVICES** (cont.)

D. Air ambulance equipment must comply with all regulations for air ambulance of Maine Emergency Medical Services, or comparable other jurisdiction.

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Air ambulance equipment shall be made available for inspection from time to time, as deemed necessary by the Office of MaineCare Services and/or Maine Emergency Medical Services, or comparable other jurisdiction.

E. In order to provide the medical equipment required for use in meeting the conditions of air ambulance transport, the provider shall not compromise any portion of the minimum equipment complement of any Maine licensed land ambulance required for emergency response.

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5.05-2 Services for Continuous Treatment in a Hospital Outpatient Department

Providers must receive prior authorization from the Office of MaineCare Services, Prior Authorization Unit (in order to transport members to and from a hospital outpatient department for treatment on a continuing basis from his or her home or a nursing home. Round trips must be medically necessary and the vehicle and personnel requirements must be met. This benefit is limited to those cases in which transportation of the member is less costly than bringing the service to the member.

Effective 5-21-09

5.05-3 Round Trips for Specialized Services

- A. Round trip ambulance services are covered for inpatients of hospitals and medical care facilities (including nursing facilities and ICFs-MR) to the nearest hospital or non-hospital treatment facility, i.e. a clinic, therapy center or a physician's office, to obtain necessary diagnostic or therapeutic services that are not available at the institution where the member is an inpatient. Round trip ambulance services must meet the criteria for medical necessity as set forth in Section 5.01-6.
- Effective 5-21-09
- B. Round trip services to and from a nursing facility (NF) or Intermediate Care Facility for People With Mental Retardation (ICF-MR) that do not meet the definition of medical necessity and reasonableness as defined in Sections 5.01-5 and 5.01-6, are the responsibility of the NF or ICF-MR, as defined in the MaineCare Benefits Manual, Section 67, Nursing Facility Services, Section 50, Intermediate Care Facility for People With Mental Retardation.

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5.05 **RESTRICTED SERVICES** (cont.)

5.05-4 Physician's Office

Ambulance Service to a physician's office may be covered under the following situations:

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- A. The trip is a round trip from a medical care facility or residence where it is less expensive to bring the member to the service than the service to the member. No payment is allowed if the trip is made only because the physician does not make calls to the member's place of residence. Round trip ambulance service to a physician's office from a nursing facility (NF) or Intermediate Care Facility for People With Mental Retardation (ICF-MR) that does not meet the definition of medical necessity and reasonableness defined in Section 5.01-5 and 5.01-6 of this policy, is the responsibility of the NF or ICF-MR as defined in the MaineCare Benefits Manual, Section 67, Nursing Facility Services, or Section 50, Intermediate Care Facility for People With Mental Retardation respectively.
- B. When transporting a member to a hospital, if the ambulance must stop at a physician's office because of the member's need for immediate attention, the ambulance will then complete the trip to the hospital when the member is ready to leave the physician's office.

5.05-5 Medical Supplies and Services Provided by Ground Ambulances

Effective 5-21-09

Separate billing is not allowed for ancillary services which include: oxygen, oxygen administration supplies such as disposable oxygen masks, intravenous therapy, EKG, endotracheal intubation, pulse oximetry, telemetry and defibrillation. RN services are also included in the base rates and are not billed separately.

5.05-6 Emergency Involuntary Admission to a Mental Hospital Ambulance Services

Effective 5-21-09

Ambulance services transporting members for emergency involuntary admission to a psychiatric facility ("Blue Paper") will be reimbursed at a rate consistent with Chapter III of this Section. In order to qualify for the Involuntary Admission to a Mental Hospital "Blue Paper" rate, the ambulance service must have a copy in the member's record of the judge-endorsed "Application for Emergency Involuntary Admission to a Mental Hospital."

Effective 5-21-09

5.05-7 Specialized Neonate Transport Services

Payment is allowed for an isolette and specialized support equipment needed to transport critically ill neonates. Services must be billed and documented as necessary by the attending physician.

Payment is allowed for services delivered to a neonate, between the age of birth and one (1) month. Services delivered to children older than one (1) month, but younger than two (2) years

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5.05 **RESTRICTED SERVICES** (cont.)

will be approved for payment if the attending physician documents the medical necessity in the member's file and forwards a copy with the bill for services.

Effective 5-21-09

5.05-8 **Down Time**

An ambulance service's reimbursement for "Down Time" may not exceed the cost of a second Base Rate for the same member's round trip to and from a medical facility.

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5.05-9 Air Ambulance Layover Charges

The Air Ambulance Layover Charge shall cover reasonable expenses incurred by employees of ambulance service providers who are covered under this Section of the MaineCare Benefits Manual, either when the return flight is delayed due to poor weather conditions or while waiting for the member when it has been determined that the charges while waiting would be less than making two separate trips. An air ambulance service may not be reimbursed for both layover charges and a second Base Rate for the same member's round trip to and from a medical facility.

Effective 5-21-09

Effective 5.05-10 Services for Non-Ambulatory Individuals

Non-ambulatory individuals who do not require the life support emergency medical services available aboard an ambulance, but cannot, due to their disability, be transported by means of conventional transportation services shall be referred to the transportation agency that serves that particular catchment area for a determination of the availability and suitability of wheelchair van services. For additional information please refer to Chapter II, Section 113, "Transportation Services," of this Manual.

5.06 **REIMBURSEMENT**

The amount of payment for services rendered shall be the lowest of the following:

- A. The amount listed in Chapter III, Section 5, "Allowances for Ambulance Services."
- Effective 5-21-09
- B. The amount allowed by the Medicare Part B carrier. Ambulance services are exempt from the coinsurance and deductible limitations otherwise set forth under Chapter I, Section 1, General Administrative Policies and Procedures in the MaineCare Benefits Manual.
- C. The ambulance's usual and customary charge.

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In accordance with Chapter I of the MaineCare Benefits Manual it is the provider to seek payment from any other source that is available for payment of the rendered service prior to billing MaineCare.

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5.07 **COPAYMENT**

A. A copayment will be charged to each MaineCare member receiving services. The amount of the copayment shall not exceed \$3.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
\$10.00 or less	\$0.50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 - or more	\$3.00

B. The member shall be responsible for copayments up to \$30.00 per month whether the copayment has been paid or not. After the \$30.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

See Chapter I of the MaineCare Benefits Manual for additional information on copayments, including exemptions and dispute resolution.

5.08 POLICIES AND PROCEDURES

5.08-1 **Records**

Records must include, but need not be limited to:

- A. Name, address and MaineCare ID number of the member;
- B. Completed Patient/Run Reporting Form; and
- C. Signed "Application for Emergency Involuntary Admission to a Mental Hospital" ("Blue Paper") form, if applicable.

5.08-2 Procedure to Request Prior Authorization (PA)

All prior authorization requests must include pertinent information concerning the nature, extent, need, and charge for the service. Requests must be in writing and sent to:

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Office of MaineCare Services Health Care Management Prior Authorization Unit 11 State House Station Augusta, ME 04333-0011

The procedure to request Prior Authorization is as follows:

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5.08 **POLICIES AND PROCEDURES** (cont.)

- A. The provider shall verify eligibility of the member in the manner described in Chapter I of the MaineCare Benefits Manual.
- B. The request for Prior Authorization shall be made by the provider either in writing or by telephone, followed by written materials.
- C. The provider shall report the following information to the Office of MaineCare Services, Prior Authorization Unit when requesting PA:
 - 1. Name of member and MaineCare ID number;
 - 2. Diagnosis;
 - 3. Physician's approval;
 - 4. Medical necessity for transport;
 - 5. Base departure (for air ambulance);
 - 6. Estimated amount of time required for air travel;
 - 7. Land ambulance involved for out of state transport of member by air ambulance; and
 - 8. Other pertinent information.

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D. Emergency cases where the provider is unable to reach the Prior Authorization Unit shall be given special consideration and may be granted retroactive authorization when all other requirements for approval listed above have been met.

Effective 5-21-09

50.8-3 **Program Integrity**

See Chapter I of the MaineCare Benefits Manual.

5.09 **BILLING INSTRUCTIONS**

- A. Billing must be accomplished in accordance with the Department's billing requirements; "Billing Instructions for CMS 1500 Claim Form."
- B. In order to receive full MaineCare reimbursement for claims submitted for a service that is defined as a copayment exemption in Chapter I, the provider must follow billing instructions.
- C. Some specialized services may require additional documentation to be submitted with the claim. Please refer to "Billing Instructions" for details.

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SECTION 5 AMBULANCE SERVICES Established 9/15/85
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5.00 INTRODUCTION

This section is a fee schedule. Providers should bill utilizing their usual and customary charges and reimbursement will be in accordance with the criteria cited below. Providers who use electronic information from the web site should note that they are still subject to the regulations pertaining to individual MaineCare benefits. Fees are subject to change without notice. Records are updated at least quarterly.

5.01 **CODING**

Effective 5-21-09

Approximately once a year the Center for Medicare and Medicaid Services (CMS) issues to participating states a Healthcare Common Procedure Coding System (HCPCS) transaction list which includes additions to and deletions from the current schedule of codes.

5.02 **DEFINITIONS**

Following are definitions for several terms which are used frequently throughout this publication:

- 5.02-1 **By Report:** This notation in the Maximum Allowances column indicates that the fee for the procedure is to be determined based on a special report. Such a procedure would be one that is rarely provided, unusual, variable, or newly developed. Pertinent information contained in the report, which must accompany the claim, should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service. Additional items which may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.
- 5.02-2 **HCPCS Codes:** Alpha-numeric codes, developed by the Department of Health and Human Services. For the most part, HCPCS codes are used to describe health care services rendered by providers other than physicians (ex: ambulance, chiropractic, etc.). There are some HCPCS codes, however, which will be used by physicians.
- 5.02-3 **Modifiers**: A modifier is a two-character code added as a suffix to the procedure code. A modifier provides the means whereby the reporting provider can indicate that a service that has been performed has been altered by some specific circumstances, but not changed in its definition or code. Modifiers and their use are discussed in greater detail below.

Effective 5-21-09 5.03

MODIFIERS

MaineCare will accept the two character modifiers listed on the following pages. Although CPT guidelines allow for the use of numeric modifiers up to five characters long (in addition to the procedure code), MaineCare only accepts and processes two character modifiers.

As with the procedure codes, there are two types of modifiers: CPT modifiers, which are numerical; and HCPCS modifiers, which are alphabetical. Modifiers can be used interchangeably with all codes; that is CPT-4 modifiers can be used with HCPCS codes, etc. Some modifiers are meant to affect the fee payable for a particular service. These are called pricing modifiers.

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5.03 **MODIFIERS** (cont.)

Other modifiers do not affect the pricing of a particular code, but they do describe more accurately the service being provided. These are called descriptive modifiers.

There are several modifiers that define services not covered by MaineCare. These modifiers have not been included in the following list. Modifier(s) listed in this section must be selected to describe the appropriate service.

Single letter modifiers must be combined to indicate the origin and destination of the trip. For example, base transport from the member's home to the hospital would be coded A0428RH, while base transport from the hospital to the member's home would be coded A0428HR.

5.03-1 **Descriptive Modifiers**

Modifier	Definition
D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes.
E	Residential, domiciliary, custodial facility.
G	Hospital-based dialysis facility (hospital or hospital-related).
Н	Hospital.
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport.
J	Non hospital-based dialysis facility.
N	Nursing facility.
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence.
S	Scene of accident or acute event.
X	(Destination code only) intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility; clinic, etc.)
QL	Patient pronounced dead after ambulance called.
D · · M I	Co.

Effective 5-21-09

5.03-2 **Pricing Modifiers**

Modifier	Definition
Н9	Court-ordered. [This modifier is to be used to designate when reimbursement should be paid at the Emergency Involuntary Admission to a Mental Hospital (Blue Paper) ambulance run and mileage rates].

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5.04 ELEMENTS OF HCPCS CODING

HCPCS codes for services are arranged in tabular form. Specific information regarding each code is given under the following headings:

1. Age: Some procedures have age limitations. Any limitations

based on the age of the member will be noted here.

2. Procedure Code: The actual HCPCS procedure code will be listed in this column.

3. HCPCS Description: The narrative description of the procedure will appear here.

4. Maximum Allowance: This column will show the maximum reimbursement

MaineCare will allow for a particular procedure. Please remember that MaineCare pays the lowest of the usual and customary charge, the Medicare maximum rate, or the

MaineCare maximum

allowance.

5. Prior Authorization/Consent: Some procedures require prior authorization in order for

MaineCare to allow payment. If prior authorization is required, it will be indicated by the message "Yes" in this column. Also, several procedures require the signing of an informed consent statement by the member. When the message "Consent" appears in this column, a copy of the MaineCare approved consent form must accompany

the claim.

6. Modifier Required: Add two-letter modifier as a suffix to codes

(origin/destination). Codes that require modifier will be

indicated by the message "yes" in this column.

7. Notations: (+) Medicare maximum reimbursement is less than

MaineCare allowed amount. Regulations allow payment up

to Medicare maximum.

(#) MaineCare will pay the lowest of the provider's usual and customary charge, the maximum allowed by Medicare,

or the fee established by MaineCare.

Some procedures are manually priced, or priced "By Report" (see the Section titled "Definitions" for an explanation of "By Report"). If a service is priced this way, the message "By Report" will appear in the Maximum Allowance column. All "By Report" codes suspend for review, which interrupts the automatic claims processing and slows payment. It is expected that most procedures can be accurately defined by a HCPCS code or a code and one or more modifiers. Every effort should be made to utilize the correct code. A complete report must accompany any claim coded in this manner.

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Not all procedures are reimbursable in every setting. If you have a question as to whether or not a particular service can be rendered in a particular setting, please consult Chapter II of the MaineCare Benefits Manual or contact your Provider Relations Specialist.

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5-21-09 5.04 **ELEMENTS OF HCPCS CODING** (cont.)

General The procedure codes and descriptions for Ambulance Services as listed below are to

be used in completing the CMS 1500.

Please Note: Where Departmental review indicates charges and payments in excess of the

Medicare Part B allowed amount at the time of service delivery, the

Department will seek restitution for any payments that exceed the Medicare

allowance.

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ALLOWED AGE	PROC. CODE	DESCRIPTION	# MAXIMUM_ ALLOWANCE	PRIOR AUTH.	REQUIRE S_ MODIFIER
ALL AGES	A0021	AMBULANCE SERVICE; OUT OF STATE; PER MILE TRANSPORT	\$2.00	YES	
BIRTH- 2YRS	A0225	AMBULANCE SERVICE; SPECIALIZED NEONATAL TRANSPORT, BASE RATE EMERGENCY ONE WAY [GROUND]	NEGOTIATED RATE		
ALL AGES	A0420	DOWN TIME, AMBULANCE WAITING TIME (ALS OR BLS), ONE HALF (1/2) HOUR INCREMENTS [starting with the second half hour]	PRICED AS CHARGED		
ALL AGES	A0424	EXTRA AMBULANCE ATTENDANT, ALS OR BLS (REQUIRES MEDICAL REVIEW)	BY REPORT	YES	
ALL AGES	A0425	GROUND MILEAGE, PER STATUTE MILE	\$2.00		
ALL AGES	A0425	GROUND MILEAGE, PER STATUTE MILE-INVOLUNTARY ADMISSION TO A MENTAL HOSPITAL	\$8.00		YES SEE NOTE D.*
ALL AGES	A0426	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1 [ALS 1]	\$141.32		
ALL AGES	A0427	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1 [ALS 1-EMERGENCY]	\$141.32		
ALL AGES	A0428	AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TRANSPORT, [BLS]	\$132.77		

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eff. -21-09	ALL AGES	A0428	AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TRANSPORT, [BLS]-INVOLUNTARY ADMISSION TO A MENTAL HOSPITAL.	\$285.00		YES SEE NOTE D.*
	ALL AGES	A0429	AMBULANCE SERVICE, BASIC LIFE SUPPORT, EMERGENCY TRANSPORT [BLS-EMERGENCY]	\$137.00		
	ALL AGES	A0430	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE-WAY [FIXED WING] (SEE NOTE B)	\$364.93 PER HALF HOUR	YES	
	ALL AGES	A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE-WAY [ROTARY WING] (SEE NOTE C)	\$2811.00	YES	
	ALL AGES	A0433	ADVANCED LIFE SUPPORT, LEVEL 2 [ALS 2]	\$141.32		
	ALL AGES	A0434	SPECIALTY CARE TRANSPORT [SCT]	\$135.76		
	ALL AGES	A0435	FIXED WING AIR MILEAGE, PER STATUTE MILE	\$4.00	YES	
	ALL AGES	A0436	ROTARY WING AIR MILEAGE, PER STATUTE MILE	BY REPORT	YES	
Eff.	ALL AGES	A0999	UNLISTED AMBULANCE SERVICE (SEE NOTE A)	BY REPORT	YES	
5-21-09	ALL AGES	A0998	AMBULANCE RESPONSE AND TREATMENT, NO TRANSPORT	\$95.00		

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5.06 **NOTES**

A. This code is to be used for air ambulance layover charges, for air ambulance landing fees, and for any other air or ground ambulance service which is not otherwise classified. Claims for such services shall be evaluated individually as the claim is processed and only actual cost will be reimbursed.

The air ambulance layover charge is limited to \$65.00 per hour, plus reasonable expenses incurred by employees covered under Chapter II, Section 5 of the MaineCare Benefits Manual either when the return flight is delayed due to poor weather conditions or while waiting for the member when it has been determined that the charges while waiting would be less than making two separate trips.

Reimbursement for air ambulance landing fees is limited to \$48.00.

Ambulance services not otherwise classified shall cover all medically necessary services not identified in any of the codes.

- B. The Half-Hour Rate shall cover all costs associated with financing the fixed wing aircraft and providing equipment, supplies, routine personnel and all necessary medical services administered to the member. The Half-Hour Rate shall also cover all administrative costs associated with providing the air ambulance services and arranging for the land ambulance services as specified in Chapter II, Section 5 of the MaineCare Benefits Manual. Each invoice shall be accompanied by a copy of the aircraft manifest to support the number of hours billed.
- C. Air Helicopter Base Rate may be billed in conjunction with Rotary Wing Air Mileage. This reimbursement shall cover all costs associated with providing equipment, supplies, personnel, and all necessary medical services provided to the member which are not already reimbursed through the air helicopter service reimbursement. The air helicopter base charge shall also cover all administrative costs associated with providing the air helicopter services and arranging for the land ambulance services as specified Chapter II, Section 5 of the MaineCare Benefits Manual.
- D. Use modifier H9 to designate Basic Life Support Non-Emergency Transports (Procedure Code A0428)

 Effective 5-21-09 Use modifier H9 to designate Basic Life Support Non-Emergency Transports (Procedure Code A0428)

 and ground mileage (Procedure Code A0425) performed under the auspices of an Emergency Involuntary Admission to a Mental Hospital (Blue Paper) commitment proceeding.